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CHAPTER VI
SURGERY: DIGESTIVE SYSTEM
CPT CODES 40000 - 49999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter VI
Surgery: Digestive System
CPT Codes 40000 - 49999

A. Introduction

The general policy statements defined previously also apply to procedures described by the CPT range of codes, 40490-49999, that deal with the digestive system. The nature of services identified in this section requires specific clarification in relationship to these general policy statements.

B. Endoscopic Services

Endoscopic services are performed in many settings, i.e. office, outpatient, and ambulatory surgical centers (ASC). Procedures that are performed as an integral part of an endoscopic procedure are considered part of the endoscopic procedure. Services such as venous access (e.g. CPT code 36000) and/or injection (e.g. CPT codes 90780-90784), non-invasive oximetry (e.g. CPT codes 94760 and 94761), anesthesia provided by the surgeon, etc. are included in the endoscopic procedure code. These column 2 codes are not to be reported separately.

1. When a diagnostic endoscopy is performed in conjunction with endoscopic therapeutic services, the appropriate CPT code to use is the most comprehensive endoscopy code describing the service performed. If the same therapeutic endoscopy service is performed repeatedly (e.g. polyp removal) in the same area described by the CPT narrative, only one CPT code is reported with one unit of service. If different therapeutic services are performed and are not adequately described by a more comprehensive CPT code, the appropriate codes can be designated in accordance with the multiple GI endoscopy rules previously established by CMS.

2. When a diagnostic endoscopy is followed by a surgical endoscopy, the diagnostic endoscopy is considered part of the surgical endoscopy (per CPT definition) and is not to be separately reported.

3. Gastroenterologic tests included in CPT codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as part of an upper endoscopy (CPT code 43235) and, therefore, CPT codes 91000 (esophageal intubation) and 91055 (gastric

intubation) should not be separately reported when performed as part of an upper endoscopic procedure. Provocative testing (CPT code 91052) can be expedited during gastrointestinal endoscopy (procurement of gastric specimens); when performed at the same time as GI endoscopy, CPT code 91052 should be coded with the -52 modifier indicating a reduced level of service was performed.

4. When a small intestinal endoscopy or enteroscopy is performed as a necessary part of a procedure, only the most comprehensive (column 1) code describing the service performed is to be reported. When services described by the range of CPT codes 44360-44386 (small intestinal endoscopies) are performed as part of another service (e.g. surgical repair or creation of enterostomy, etc.), these codes are not separately reported. As noted previously, when an endoscopic procedure is confirmatory or is performed to establish anatomical landmarks ("scout" endoscopy), the endoscopic procedure is not separately reported. In the case where the endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform a more extensive (open) procedure is made, the endoscopic procedure may be separately reported. The -58 modifier may be used to indicate that the diagnostic endoscopy and the more extensive, open procedure are staged or planned services.

5. When endoscopic esophageal dilation is performed, the appropriate endoscopic esophageal dilation code is to be reported. The CPT codes 43450-43458 (dilation of esophagus) are not used in addition (even if attempted unsuccessfully prior to endoscopic dilation); in such a case, the -22 modifier could be used to indicate an unusual endoscopic dilation procedure.

6. When it is necessary to perform diagnostic endoscopy of the hepatic/biliary/pancreatic system using separate approaches (e.g. biliary T-tube endoscopy with ERCP, etc.) the appropriate CPT codes for both may be reported. However, the code should include the -51 modifier indicating multiple procedures were performed at the same session.

7. When intubation of the GI tract is performed (e.g. percutaneous G-tube placement, etc.), it is not appropriate to bill a separate code for tube removal. Specifically, the CPT code 43247 (endoscopic removal of foreign body) is not to be reported for routine removal of therapeutic devices previously placed.

8. When an endoscopic or open procedure is performed and a biopsy is also performed, followed by excision, destruction or removal of the biopsied lesion, the biopsy is not separately reported. Additionally, when bleeding results from an endoscopic or surgical service, the control of bleeding at the time of the service is included in the endoscopic procedure. Separate procedure codes for control of bleeding are not to be coded. In the case of endoscopy, if it is necessary to repeat the endoscopy at a later time during the same day to control bleeding, a procedure code for endoscopic control of bleeding may be reported with the -78 modifier, indicating that this service represents a return to the endoscopy suite or operating room for a related procedure during the postoperative period. In the case of open surgical services, the appropriate complication codes may be reported if a return to the operating room is necessary, but the complication code should not be reported if the complication described by the CPT code occurred during the same operative session.

9. Only the most extensive endoscopic procedure is reported for a session. For example if a sigmoidoscopy is completed and the physician performs a colonoscopy during the same session only the colonoscopy, is coded. It is, however, acceptable to bill for multiple services provided during an endoscopic procedure (with the exception of treating bleeding induced by the procedure); these services would be reimbursed under the multiple endoscopic payment rules for gastrointestinal endoscopy.

10. When a transabdominal colonoscopy (via colotomy)(CPT code 45355) and/or standard sigmoidoscopy or colonoscopy is performed as a necessary part of an open procedure (e.g. colectomy), the endoscopic procedure(s) is (are) not separately reported. On the other hand, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the procedure(s) may be reported separately. The -58 modifier may be used to indicate that the diagnostic endoscopy and the open procedure are staged or planned services.

C. Abdominal Procedures

When any open abdominal procedure is performed, an exploration of the surgical field is routinely performed to identify anatomic structures or any anomalies that may be present. Accordingly, an exploratory laparotomy (CPT code 49000) is not separately reported with any open abdominal procedure. If routine exploration of the abdomen during an open abdominal procedure

identifies abnormalities requiring a more extensive surgical field that makes the procedure unusual, the -22 modifier may be reported with supporting documentation in the medical record, indicating that an unusual procedural service was performed.

When, in the course of a hepatectomy, a cholecystectomy is necessary in order to successfully perform the hepatectomy, a separate procedure code is not coded for the cholecystectomy; component column 2 procedures necessary to perform a more comprehensive column 1 procedure are included in the column 1 code describing the more comprehensive service.

Appendectomies are commonly performed incidentally during many abdominal procedures. The appendectomy is only to be reported separately if it is medically necessary. If done incidental to another procedure, the appendectomy would be included in the major procedure performed.

When, in the course of an open abdominal procedure, a hernia repair is performed, a service is reported only if the hernia repair is medically necessary at a different incisional site. Incidental hernia repair in the course of an abdominal procedure that is not medically necessary should not be reported. The medical record should document the medical necessity of the service if it is reported.

When a recurrent hernia requires repair, the appropriate recurrent hernia repair code is reported. A code for incisional hernia repair is not to be reported in addition to the recurrent hernia repair unless a medically necessary incisional hernia repair is performed at a different site. In this case, the -59 modifier should be attached to the incisional hernia repair code.

D. General Policy Statements

1. When a vagotomy is performed in conjunction with esophageal or gastric surgery, the appropriate CPT code describing the comprehensive column 1 coded service is reported. The range of CPT codes 64752-64760 includes services described by the vagotomy codes performed as separate procedures and are not reported in addition to esophageal or gastric surgical CPT codes (e.g. 43635-43641) which include vagotomy as part of the service.

2. When a closure of an enterostomy or enterovesical fistula requires the resection and anastomosis of a segment of bowel, the

CPT codes 44626 and 44661, include the anastomosis or the enteric resection. Accordingly, additional enteric resection codes are not to be reported.

3. In accordance with the sequential procedure policy, only one code for hemorrhoidectomy is reported; the most extensive procedure necessary to successfully accomplish the hemorrhoidectomy would be appropriate. Additionally, if, in the course of a hemorrhoidectomy, an abscess is identified and drained, a separate procedure code is not reported for the incision and drainage, as this was performed in the course of the hemorrhoidectomy. If the incision and drainage of the abscess occurred at a different site than the hemorrhoidectomy, then this procedure could appropriately be reported with a -59 modifier.

4. A number of groups of codes describe surgical procedures of a progressively more comprehensive nature or with different approaches to accomplish similar services. In general, these groups of codes are not to be reported together (see mutually exclusive policy). While a number of these groups of codes exist in CPT, several specific examples include CPT codes 45110-45123 for proctectomies, CPT codes 44140-44160 for colectomies, CPT codes 43620-43639 for gastrectomies, and CPT codes 48140-48180 for pancreatectomies.

5. When it is necessary to create or revise an enterostomy, or remove or excise a section of bowel due to fistula formation, a separate enterostomy closure code or fistula closure code is not reported. In the case of creating or revising an enterostomy, the closure is mutually exclusive and in the case of fistula excision, the closure is included in the excision procedure.

6. Because the digestive tract is bordered by a mucocutaneous margin, several CPT codes may define services involving biopsy, destruction, excision, removal, etc. of lesions of this margin. When a lesion involving this margin is identified and it is medically necessary to remove, only one code which most accurately describes the service performed should be submitted, generally either from the CPT section describing integumentary services (10040-19499) or digestive services (40490-49999). For example, if a patient presents with a benign lip lesion, and it is removed with a wedge excision, it would be acceptable to bill the CPT code 40510 (excision of lip) or the appropriate code from CPT codes 11440-11446 (excision of lesions); billing a code from both sections would be inappropriate.

7. Laparoscopic procedures performed in place of an open procedure are subject to the standard surgical practice guidelines.

8. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

9. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.